STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 15,539
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision by the Department of Social Welfare denying her request that her minor son be exempted from transferring to a managed care component of the Medicaid program.

FINDINGS OF FACT

1. The petitioner is the mother of a seven-year-old boy who receives Medicaid benefits. He has Attention Deficit, Hyperactivity Disorder (ADHD) and has been treated for this by a pediatrician who has also been intensely involved as a member of the team managing his educational program at his school.

2. In May of this year, the petitioner was notified by DSW that her son would be enrolled in a managed care program effective July 1, 1998. Because her son's pediatrician does not participate as a provider in either managed care program offered by the Department, the petitioner asked for an exemption from this program. She was denied on May 28, 1998 because she did not meet any of the criteria for exemption. She appealed that decision.

3. Prior to her hearing, the petitioner was provided with a copy of the regulations setting forth the criteria

for exemptions from the managed care program. She stated at the hearing that she had reviewed each exception and that she did not meet any of them. The exceptions were reviewed again with her after she made this statement. She asks that a special exception be made for her son so he can continue in the care of his current pediatrician, particularly because he is now in the process of some new evaluations and tests. Her son feels comfortable with this pediatrician whom the petitioner characterized as particularly interested in and experienced with the problems of ADHD children.

ORDER

The decision of the Department is affirmed.

REASONS

The managed health care program employed by Medicaid requires the Department to make a monthly payment to the plan for each person enrolled in the program, as opposed to paying individually for each health care service. Persons found eligible for Medicaid benefits are required to enroll in one of two managed health care plans unless they are excluded by one of the provisions in regulation M103. M103.2 Those exceptions are as follows:

M103 Benefit Delivery Systems

Covered services for eligible recipients are provided through fee-for-service and managed health care delivery systems. With the exception of the following groups, all Medicaid recipients are required to enroll in managed health care plans, subject to plan availability and capacity. Recipients who are not eligible for managed health care plan enrollment are:

a) recipients who also have Medicare (Parts A and/or B);

b) home and community-based waiver recipients;

c) recipients living in long-term care facilities, including ICF/MRs;

d) recipients who are receiving hospice care when they are found eligible for Medicaid;

e) children under age 21 enrolled in the high-tech home care program;

f) recipients who have private insurance that includes both hospital and physician's services;

g) recipients residing in a geographic area where only one managed health care plan operates, unless they choose to be enrolled in that plan; NOTE: The standards the department uses to determine the geographic area that a managed health care plan serves are defined in the Welfare Procedures Manual at P-2443; these standards are in accordance with federal standards for access to care and the Vermont Health Resource Management Plan;

h) recipients who meet a spend-down who are not enrolled in a VHAP managed health care plan.

Exceptions from required enrollment may be made for individuals who would otherwise be enrolled in managed care for three months or less based on known changes, such as becoming Medicare-eligible.

For recipients required to enroll in managed health care plans, no payment will be made for services obtained outside the plan except for covered services

designated wrap-around benefits. (See M 103.22)[1]

The petitioner agrees that her son does not meet any of the exceptions in paragraphs a through h of the above regulation. Her request for an exemption is based on the fact that she wants him to stay with his current pediatrician because she believes it would be in the best interests of her son. The regulations do not, however, set forth such a reason as an exemption. The Board has no authority under the regulations to carve out other exemptions. It must be concluded, therefore, that as the Department's decision rests on its regulation, it must he upheld. See Fair Hearings No. 15,152, 15,499, 3 V.S.A. э 3091(d) and Fair Hearing Rule 17.

The petitioner should be aware that once she is enrolled in the plan, she can request payment for a physician who is not in the plan if she can show that no provider in the plan has the appropriate training or experience to carry out her son's health care plan. See "Rule 10" of the Department of Banking and Insurance Regulations on Managed Health Care. That is a request she must take up with the administrators of the managed health care plan she chooses. If she can obtain no satisfactory

[1] M103.22 provides that "[m]edicaid recipients enrolled in managed health care plans are eligible to receive additional services as defined in the State Plan and by regulation that are not included in the managed health care plan package. . . ."

result from such a request, she can appeal that matter to the Board.

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